MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

April 26, 2002

Medicare+Choice risk adjustment: an update

ISSUE: Health risk-adjustment is an essential component in the M+C payment system, because otherwise plans would have incentives to attract healthier-than-average enrollees and would not be adequately compensated if they treated a less healthy population. Further, successfully adjusting for health risk is vital for ensuring the Commission's recommendation that the payment system be financially neutral between enrollees in M+C plans and beneficiaries in traditional fee-for-service Medicare. On March 29, CMS announced its current plan for the risk-adjustment process.

KEY POINTS: Medicare+Choice plans are paid a monthly capitated rate for each beneficiary enrolled. To account for predictable differences, in their use of health care, the rate is adjusted for beneficiaries' demographic and health risk factors. Currently, the health risk factors are calculated based on diagnoses of the patient pulled from any hospital discharges the beneficiary had during the previous year. This year, only 10 percent of payment is determined by the health risk factors, and the remainder is based on demographics.

The current hospital-only risk adjustment system is better at predicting Medicare costs than the previously-used demographic system, but it still systematically overpays for people with relatively low health risk and underpays for those with high risk. To address this, the Benefits Improvement and Protection Act of 2000 mandated that M+C payments reflect health risk adjustment factors based on both inpatient and ambulatory data beginning January 2004 (to be gradually phased in until complete in 2007). Medicare administrators had planned to comply by calculating risk adjusters based on diagnoses from fee-for-service claims and from data that would have been collected from all encounters M+C enrollees had in the inpatient hospital, outpatient hospital, and physician office settings. Many M+C plan sponsors protested that such a system would impose data collection requirements that would overburden them. Secretary Thompson suspended work on this system last May and asked CMS staff to explore alternatives.

The new health risk adjustment system proposed by CMS would vary payment for M+C enrollees, based on whether they had one or more of 61 medical conditions during the previous year. The presence of those conditions would be determined by diagnoses either from fee-for-service claims (for those beneficiaries in the traditional Medicare program in the base year) or from submissions by M+C plans. Applicable diagnoses could be made in either inpatient hospital or ambulatory (outpatient hospital or physician office) settings. The proposed model is a better predictor of Medicare cost that the current inpatient hospital only model. The plan data submission process appears to have been simplified as much as possible while still being able to support the chosen model, however some M+C organizations still feel that the data collection burden will be too great. Payments made beginning in January 2004 will use this model.

ACTION: Staff will brief the Commission on the proposed system and Commissioners will have the opportunity to comment.

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